Appendix B

GIST Recommendations

FINANCING COMMITTEE MECHANISMS RECOMMENDATIONS

1. 20 For 1 Against Use existing funding efficiently and effectively. Use State general revenue to leverage Medicaid federal funds when possible. DHS will work with its divisions and other state agencies providing services to people with disabilities (Health Department, Rehabilitation Services, Spinal Cord Commission, etc.) to determine whether state-funded programs can be incorporated into Medicaid programs to take advantage of federal matching funds. The review should include analysis of the number of people who can be served and the value of their benefits as state-funded programs versus Medicaid waiver programs. (Adopted by GIST, 2-4-02)

2. 19 For 3 Against GIST Review of DHS Budget Proposal.
Request copies of the preliminary and final Priority Requests and Briefing Packets for DHS for the 03-05 Biennium Budget.

A. Request copies of the schedule for the Biennium Budget Cycle.
B. Propose specific priority requests.
C. Request that DHS allow the GIST to review proposed Special Language and legislative initiatives.
D. Request monthly updates on waiting lists for institutions and waiver services. (Adopted by GIST, 3-4-02)

3. 19 For 1 Against Restructure DDS funding to meet consumer and family needs. DHS, in coordination with the Governor's Office and the DDS Board, should address restructuring all available DDS funding streams to allow maximum flexibility to utilize all available dollars to meet the needs of the population in accordance with consumer and family choice and direction.

4. 21 For 0 Against Restructure mental health service delivery.
DHS, in coordination with the Governor's Office and the Arkansas Mental Health Planning and Advisory Council, should address restructuring the Mental Health service delivery system including building smaller facilities (less than 16 residents) to enable accessing of Medicaid funding streams.

5. 19 For 1 Against Use existing housing funds to finance integrated housing and community facilities. Arkansas Development Finance Authority (ADFA) should help meet the housing needs of people with disabilities, through Section 8 rental subsidies, and by providing financing for developers of integrated housing and community facilities through the Home Investment Partnerships Program (HOME), Community Development Block Grant (CDBG) program, and low-income housing tax credit financing.

6. 18 For 2 Against Reward housing developers who incorporate universal design. Arkansas Development Finance Authority (ADFA) should award extra points to proposals from developers who incorporate universal design into their projects.

7. 18 For 2 Against Reduce use of institutional care, which is not integrated and generally costs more than home and community supports and services. Provide information to applicants about alternatives to institutionalization. All long-term care institutions (private and public nursing homes, human development centers, and ICF/MRs) will provide each applicant, including those who are private pay, with a packet of information prepared by DHS about alternatives to institutional care. (Adopted by GIST, 2/4/02)

8. 16 For 3 Against Reduce admissions through independent eligibility assessment and choice of alternatives. Medical eligibility for Medicaid-covered institutional level care will be assessed uniformly for applicants and clients in both institutional and community settings. Medical eligibility assessments will be conducted face-to-face by teams of at least two assessors who are not affiliated with the institution or a provider to avoid any conflict of interest. Teams will assess people in both institutions and community settings, for initial assessments and all periodic reassessments.

If possible, applicants for institutional care (public and private nursing homes, human development centers, and ICF/MRs) will be assessed prior to admission to a facility. The assessors will be professionals, such as registered nurses, rehabilitation counselors, or social workers, who have experience working with the client group and are familiar with community supports and services. Assessors will be tested for reliability. Assessors will advise the client or guardian about their support and service options at initial assessments and each reassessment, and allow them to make an informed choice.

9. 19 For 2 Against Transitions from Human Development Centers to community. Identify Human Development Center residents appropriate and willing to transition to community placements, and develop the necessary flexibility with respect to services and supports to facilitate transition to community settings. Guarantee the option of returning to the HDC if the community placement is unsuccessful.

10. 16 For 4 Against New Roles for the Human Development Centers
As residents are transitioned out of the Human Development Centers, the HDC's should assume new roles such as providing quality assurance for home and community services, and providing services such as diagnosis, short-term treatment, community placement, and respite care.

11. 21 For 0 Against Continue the Passages program to help resident's transition to community. Continue the Passages program to help residents of institutions move back into the community by providing case management, access to Medicaid services, and assistance with the costs of housing and setting up a household.

12. 21 For 0 Against Improve access to cost-effective home and community-based services by making them as easy or easier to access as institutional services. Reduce waiting lists for home and community waivers.
Identify all waiver waiting lists and project future needs. Set timeline to steadily reduce waiting lists.

13. 20 For 1 Against Reduce response times for obtaining home and community services. The State should reduce the time necessary to access community services to equal that required to access institutional services.

14. 18 For 3 Against Improve access of underserved groups through amended or new waivers. DHS should amend current Medicaid waivers or create new waivers to better serve those individuals not receiving adequate care. Existing programs using general revenues to serve these populations could be a potential source of matching funds. Program development should consider the special needs of these and other groups:

A. Catastrophic care waiver for very high need clients (e.g., quadriplegic, ventilator dependent, dual diagnosis) with cost-neutrality based on comparison to the Benton Services Center.

B. Individuals with traumatic brain injuries, end stage renal disease, children and adults with cognitive disabilities and behavioral needs, medically fragile children and adults (spina bifida, CF, chronic health issues), deaf-blind persons, and other underserved populations with functional impairments.

15. 17 For 2 Against Fully fund the Developmental Disability waiver and increase flexibility. Arkansas should fund the Developmental Disabilities Services waiver waiting list. The DDS waiver should be fully funded to address the waiting list and the caps that prevent this waiver from being an alternative to HDCs and ICF/MRs. The $160 a day cap on direct care services should be eliminated.

A. If the cap cannot be eliminated, then the rate should be adjusted upward to reflect cost of living increases over the past nine years; and

B. The method of computing when the cap is reached should be changed to reflect the annual cost of service. This would:

i. eliminate bias against working families;

ii. increase family flexibility;

iii. save State general revenue and Social Services Block Grant dollars.

16. 20 For 1 Against Reduce eligibility age for Alternatives waiver from 21 to 18 years. DHS, Division of Adult and Aging Services should change the eligible age for services from 21 to 18 years for the Alternatives Waiver.

17. 16 For 4 Against Review and adjust Medicaid rates for home and community services. Medicaid reimbursement for home and community services should be reviewed at least every two years, and rates should be adjusted to insure that providers can hire and retain good workers by offering competitive pay and benefits.

18. 21 For 0 Against Address issues related to Nurse Practice Act.
DHS and others should work with the State Board of Nursing to insure that the Nurse Practice Act is not a barrier to providing care in the community.

19. 19 For 2 Against Identify and eliminate institutional bias.
DHS should identify and eliminate institutional bias in Medicaid long-term care eligibility, services, and reimbursement.

20. 21 For 0 Against Speed-up access to waivers with Fast Track process.
Develop and implement a Fast Track eligibility process for Medicaid waiver programs.

21. 20 For 1 Against Review criteria for institutional care and waivers.
DHS should review criteria for institutional care [which are also the criteria for waiver eligibility] to insure that they are fair, consistent, reliable, clearly stated and easy to interpret, and do not exclude persons with some disabilities or medical conditions [e.g., non-DD adults with cognitive impairment].

22. 20 For 1 Against Insure that home and community services meet the needs of people with severe disabilities, so they can successfully live in the community. Increase consumer direction for waiver and State Plan services.
Amend the waivers and home and community services in the Medicaid State Plan to include more consumer direction of services, and a cash and counseling option that enables consumers to obtain appropriate supports and services that best meet their needs.

23. 17 For 4 Against Equalize access to services between community and institutions. Community-based services should be expanded to include all services (e.g., prescriptions, dental) that an individual requires to maintain community placement. The menu of service options should never be less than what is available in institutions for comparable population.

24. 13 For 8 Against Remove benefit limits within waivers.
DHS should consider removing all caps within existing waivers. Given existing restraints on the total cost of a waiver plan of care, caps on the components that make up the waiver are unnecessarily restrictive. Specifically, caps on technology/equipment limit an individual's options to trade technology for other services even when the technology may reduce the need for other services.

25. 14 For 7 Against Require providers to have back-up caregivers for “no shows”. DHS contracts should include a requirement that providers must have back-up personnel to serve clients when regularly scheduled staff is a “no shows.”

26. 18 For 3 Against Restructure DDTCS to be more flexible.
Restructure DDTCS [community provider] programs to become more flexible in providing home and community-based services with more consumer direction and less center-based.

27. 16 For 3 Against Develop more options for school age children with disabilities. DHS, in partnership with the Department of Education, needs to develop options for school age children with disabilities that can be accessed during the summer months and other times when school is not in session.

28. 15 For 4 Against Pilot use of community boards. DHS divisions should pilot the use of community boards as a means of pooling resources and adding consumer direction.

29. 14 For 6 Against Increase integration into the community at all levels.
Integrate DDTCS pre-school day care. Restructure DDTCS pre-school day care so that a minimum of 50% non-disabled children is served. Families should have the ability and option to choose any integrated day care.

30. 19 For 0 Against State agencies should develop plans to integrate community facilities. State agencies, including the Department of Education, which serve people with disabilities and pay for services or operate community facilities or programs such as day treatment, sheltered workshops, or educational programs, should develop plans, with public input, to increase opportunities for programs and services to be provided in integrated settings.

31. 20 For 0 Against Arkansas Rehabilitation Services should set standards for meaningful work and compensation. ARS should set standards for employment programs to provide more meaningful work and compensation, including seeking private sector employment.

32. 18 For 2 Against Improve quality of life in institutions.
Improve quality of life in institutions through strategies to increase community integration, and/or encourage home-like living arrangements, such as the "Eden Alternative".

33. 19 For 1 Against Develop new, non-tax resources. Grants for Olmstead implementation. The State should make a concerted effort to apply for federal and private grants that will enhance the goals of implementing the Olmstead decision. Consumers should be involved in development of grant applications.

34. 17 For 3 Against Promote volunteer care giving programs
The State should encourage volunteer programs that mobilize people to help provide care in the community, such as the *Faith In Action* projects that encourage congregations to sponsor care giving programs. Churches and other non-profits should also be encouraged to play a greater role in developing and operating housing and long-term care facilities.

35. 19 For 1 Against Encourage increased private spending on long-term care.
Group long-term care insurance for State employees. The State of Arkansas should offer high quality, high benefit group long-term care insurance to all state employees as an employee benefit. Employees would pay the full premium. Group long-term care is much less expensive to employees than individual policies, encouraging people to plan ahead for long-term care costs. It also enables spouses and possibly other family members to buy policies at a reduced price. The State benefits by providing an attractive benefit at little cost, and by reducing its future Medicaid long-term care costs.

36. 19 For 2 Against Promote group long-term care insurance among private employers. The State should encourage private employers to provide group long-term care insurance to their employees, as a means of lowering premiums for employees, thereby increasing coverage and reducing future long-term care costs to the State

37. 19 For 2 Against Develop strategies to reduce future demand for long-term care. Risk factors for acquired disabilities and institutionalization.
DHS should identify risk factors that lead to acquired disabilities and institutionalization and identify which populations are at greatest risk. For example, among the elderly, factors may include noncompliance with prescription drugs, fall hazards in the home, lack of caregiver support, malnutrition, and muscle atrophy due to inactivity. Programs should be developed to reduce or postpone acquired disabilities and institutionalization.

38. 15 For 5 Against Develop a database of long-term care applicants and consumers to collect data to improve management decision-making and program design. DHS should develop and maintain a database of applicants and consumers of Medicaid long-term care, including financial data, and medical conditions, to help determine the impact of proposed policies. An advisory committee should be formed to help determine data needed and make sure clients' confidentiality is protected.

39. 20 For 0 Against To measure the cost of transition.
Determine the average cost of transitioning institutional residents back into the community, either through a pilot project or by reviewing cases from the Passages program and other case-managed transitions.

LONG-TERM CARE WORKFORCE

40. 21 For 0 Against. Develop a reliable payroll system for consumer-directed workers, so workers will be paid in a timely manner and consumers will not be left without care.

41. 16 For 4 Against All Medicaid provider agencies should withhold payroll taxes and Social Security from their employees' paychecks. Medicaid is funded by state and federal tax dollars and it is bad public policy to allow some providers to routinely avoid withholding taxes. This practice also raises questions about whether the employers can meet both supervision requirements and the IRS test for independent contractors. Employing home care attendants as "independent contractors" also jeopardizes the employees' Social Security retirement and disability benefits.

42. 17 For 4 Against. Medicaid should reimburse providers of home and community services for training of attendants, as they reimburse nursing facilities for aide training.

43. 20 For 0 Against Request that the Department of Finance and Administration research the possibility of private non-profit provider agencies participating in state health insurance and retirement programs, with provider agencies collecting and paying the employer and employee contributions.

NOTHING ABOUT ME WITHOUT ME

44. 16 For 5 Against. The Medicaid Advisory Board needs to be Governor-appointed and include Medicaid consumers and consumer representatives.

LEGISLATIVE RECOMMENDATIONS

45. 14 For 7 Against The GIST encourages the Governor and the Legislature to consider using the Tobacco Settlement Trust Funds as a partial source of temporary assistance to Medicaid. (Adopted by GIST, 1-7-02)

46. 20 For 1 Against The GIST encourages the Arkansas Congressional delegation to seek a temporary 10% increase in the federal Medicaid match rate. (Adopted by GIST, 1-7-02)

47. 14 For 6 Against The General Assembly should not renew special language in the DDS/DHS Appropriations Bill limiting any new, willing provider or excluding new, willing providers of developmental disability services.

48. 15 For 5 Against Eliminate the Health Services Permit Commission and Agency.

49. 18 For 0 Against The General Assembly should enact mental health parity legislation, to require health insurers to cover mental health care as they cover treatment of physical illnesses. [The federal ERISA law probably exempts employer-sponsored health care plans, so a majority of workers may not be affected]

50. 19 For 2 Against The GIST encourages the Arkansas Congressional delegation to support an increase in Social Services Block Grant (SSBG) funding from $1.7 Billion to at least $2.38 Billion. SSBG is a vital source of funding for services to the most vulnerable individuals in our state —
low-income children, elderly, and people with disabilities, and victims of abuse and neglect.

ACCESS & ELIGIBILITY RECOMMENDATIONS

These recommendations are gleaned from the Olmstead Task Force Access & Eligibility Committee Report and do not appear to have been covered by any GIST Committee:

51. 19 For 1 Against DHS should allow provider agencies to hire consumers' family members to provide Medicaid in-home services under the same conditions as family members can be hired for IndependentChoices. Hiring of family members should also be extended to waiver services.

52. 19 For 2 Against Arkansas Medicaid conducted a successful marketing and enrollment campaign for ARKids First. Some of the approaches utilized in the ARKids First program should be utilized in Medicaid programs for people with disabilities, to inform people about the programs and make eligibility determination more user-friendly.

53. 16 For 4 Against Medicaid asset limits should be adjusted, especially for persons with disabilities who are unable to work and acquire assets. Homeowners living in their homes should be allowed at least $10,000 in savings for contingencies, such as replacing their roof or furnace. Non-homeowners living in the community also need savings to pay for car/van repairs or replacement, prescriptions not covered by Medicaid, etc.

54. 17 For 4 Against Married persons applying for home and community-based waivers should have the same spousal impoverishment protection as married nursing home applicants. When a married person enters a nursing home, the community spouse can keep up to $89,000 in joint assets, and the institutionalized spouse can retain $2,000. Married waiver applicants are only allowed $3,000 in joint assets (not counting the home).

55. 19 For 1 Against DHS should study the feasibility of a spend-down option for selected Medicaid programs, to enable applicants to "buy into" Medicaid when they exceed income limits.

56. 14 For 6 Against Medicaid reimbursement structure should mandate and fund minimum compensation levels for attendant care staff. The intent is that attendants share in rate increases, and that Medicaid take responsibility for funding wages and benefits that are adequate to hire and retain workers.

57. 15 For 5 Against Targeted case management is an important service to help people with disabilities arrange and monitor the services they need to live in the community. Current Medicaid reimbursement does not cover the cost of providing this service due to a low hourly rate and numerous exclusions. A new reimbursement system for targeted case management should be developed that is adequate to cover supervision, training, travel time, employee benefits, office expenses, etc.

58. 19 For 1 Against Improve Medicaid eligibility determination and response times by forming Quality Improvement teams of DHS employees and other stakeholders to recommend improvements. This is an issue for access and service delivery.

STAFFING RECOMMENDATIONS

GOALS FOR RECRUITMENT OF HEALTHCARE WORKERS

59. 20 For 0 Against Create a public education/awareness program to put the role of caregiver in the proper perspective. The job of caring for or assisting our loved ones to attain their full potential and participate in community life should be regarded as a worthwhile, quality profession and be compensated accordingly. Steps must be taken to stimulate this attitude adjustment. Ask for assistance from the Governor's office and DHS for a media campaign, including TV spots.

COLLABORATIONS WITH THE ARKANSAS WORKFORCE INVESTMENT BOARD

60. 17 For 2 Against. Policy makers need a coordinated, inter-agency system of data collection to estimate current, and project future, needs for direct care workers to evaluate existing data on the healthcare labor market.

61. 21 For 0 Against Create a direct care worker registry or "Caregiver Database" that will be accessible (By Internet, phone, or in County, City, and local Workforce Investment Centers) to both providers and consumers wishing to hire and direct their own personal care attendant.

A statewide registry of caregivers that is accessible on a website and in City, County and local Workforce Investment Center offices will help bring caregivers, who no longer work for many different reasons, back into the system and give them the option to work:

- In a different setting
- With a different client population, or
- On a different schedule with more or fewer hours.

62. 15 For 5 Against Develop a career ladder for health care workers with opportunities for career advancement. Create opportunities for skill building and access to better-paying jobs.

63. 12 For 8 Against Develop a system to rescue those caregivers who cannot meet their career goals due to lack of training, lack of funds, lack of aptitude or family obligations. Redirect them to a less challenging care giving role (e.g., attendant for a consumer who directs his own care or sitter for an elderly person).

64. 20 For 0 Against Distribute information on jobs in health care and opportunities for education at local Workforce Investment Centers.

65. 18 For 1 Against Encourage partnerships between local Workforce Investment Centers and industry heads and private training organizations.

66. 18 For 2 Against Explore collaborative efforts to develop the arworks.org website to match employees with employers (including consumers who wish to direct their own care).

EDUCATION OF HEALTHCARE WORKERS

67. 13 For 7 Against Create a database that lists all training centers and all employers in the State so that trainers can provide their graduates with local employment opportunities and employers can stimulate the recruitment of applicants with the promise of immediate employment.

68. 15 For 5 Against Create a statewide system of paraprofessional training centers using standardized curricula.

69. 18 For 1 Against Develop training curricula targeted for trainees with limited English language capabilities or literacy and numeric skills. Explore educational programs that connect recent immigrants to direct care employment, such as ESOL (English for Speakers of Other Languages) training. Current curricula also fail to address basic inter-personal communication and problem-solving skills.

70. 16 For 3 Against Create abbreviated packages of courses (educational modules) to allow caregivers to change jobs:

- Laterally (e.g., CNA in nursing home to psychiatric aide)
- Up (career ladder; e.g., CNA to LPN)
- Down (e.g., failure to pass exams shouldn't result in loss of a potential caregiver)

71. 12 For 6 Against Fund loan forgiveness and low-interest loan programs, scholarships and fellowships. Give health care employers priority access to workplace training funds from the Department of Labor, the Department of Education, the Department of Transitional Assistance, and the Workforce Training Fund of the Unemployment Compensation Fund.

72. 18 For 2 Against Promote innovative supervisory and management techniques.

RETENTION OF HEALTHCARE WORKERS

73. 14 For 5 Against Increase nurse and paraprofessional wage and benefit levels.

74. 14 For 5 Against Reward longevity with step increases in pay**.**

75. 12 For 6 Against Ensure wage parity across the health care sector.

76. 20 For 1 Against Examine the Medicaid reimbursement system for workers providing consumer-directed care. Ensure that wages are paid promptly and that contracting fees for paperwork are paid by DHS rather than subtracted from wages. Study ways to decrease data entry errors that result in delayed payments to workers.

77. 15 For 6 Against Provide health insurance for health care workers through:

- Sliding-scale Medicaid buy-ins for paraprofessionals;
- Pass-through health insurance coverage costs;
- State support for leveraging the collective purchasing power of health care employers with private insurers, and/or
- Access to public health insurance programs for children of eligible employees.

78. 14 For 7 Against Implement wage pass-throughs for direct-care workers that can be used only for wages and/or benefits. This would include full reimbursement for providers who pay higher shift differentials; weekend, holiday and overtime pay; sick leave and vacation time; and step increases for job tenure.

79. 20 For 0 Against Support provider consortia that, by joining together, can offer their employees full-time work and better benefits through pooled employee assistance and training programs. Ensuring full-time employment for direct-care workers will make them eligible for full Social Security benefits and employer group health insurance plans.

80. 17 For 2 Against Support caregiver associations to provide direct-care workers with peer support, educational opportunities and a sense of self worth.

81. 17 For 2 Against Create a welfare development fund for health care workers to provide targeted funding to overcome employment barriers and to support pre- and post-employment education. Investigate modifications in public supports to provide assistance with childcare, transportation, etc. Use Transitional Assistance to Needy Families' (TANF) funds to provide low-wage workers with expanded access to childcare and transportation.

82. 16 For 3 Against Evaluate the success rate of existing Welfare-to-Work Programs. Make recommendations to address multiple barriers to employment (e.g., substance abuse, physical or mental disabilities, limited resources for transportation and childcare).

<u>RECOMMENDATIONS TO CREATE A NEW POOL OF DIRECT-CARE WORKERS</u>

83. 15 For 4 Against Make long-term care the gateway to employment for new workers. Stimulate expansion of the qualified labor pool by providing targeted public supports for recent immigrants, people transitioning from welfare to work, and low-income individuals who need some kind of assistance to succeed.

84. 17 For 2 Against Get back all those caregivers who have left their profession by recruiting the professionals and paraprofessionals currently holding licenses, but not

practicing. Improvements in wages, benefits and working conditions may persuade this large potential pool of workers to return to careers in care giving.

Utilize the database of the Office of Long-term Care to contact certified nursing assistants (CNAs) who no longer work as CNAs. Contact the Board of Nursing for similar information on both registered (RNs) and licensed practical nurses (LPNs).

85. 19 For 0 Against Recruit nontraditional workers:

1. Older workers: Hire mature and disadvantaged workers in care giving jobs. Explore collaborative efforts with organizations like Green Thumb to provide training and placement of older and/or disadvantaged workers in care giving jobs. Now that there is no longer a penalty for individuals receiving Social Security who wish to continue working, there is a large pool of older workers for full- or part-time employment.
2. Workers with disabilities.
3. Part-time workers or workers willing to share jobs.

86. 19 For 0 Against Use the Ticket to Work and Incentives Improvement Act of 1999 to encourage people with disabilities to seek employment.

RECOMMENDATIONS TO SUPPORT FAMILY CAREGIVERS

87. 18 For 1 Against Request that CMS expand provisions for Medicaid payments to family members who provide care.

88. 16 For 3 Against Recognize aging and care giving as women's issues. Most caregivers are women and most older people are also women. Enlist the help of the Women's Project.

89. 18 For 2 Against Provide respite care for the caregiver. Encourage long-term care providers to explore day care and respite care options in existing facilities with low occupancy rates as part of a continuum of care. Examine the reimbursement systems for these services and streamline paperwork to make them more readily available to family caregivers and more financially attractive to providers.

CREATION OF A LONG-TERM CARE COMMISSION

90. 8 For 12 Against Create a legislature-sponsored, multi-stakeholder, consumer-driven Long-Term Care Commission to regulate all aspects of long-term care, both institutional and home- and community-based.

This Commission will incorporate both the Health Services Permit Agency (HSA) and the 9-member Health Services Permit Commission (which will cease to exist as a separate entity).

- The HSA will continue to generate projected bed need for institutional care, but expand its scope to include calculations of need for all the various supports and services in the community. This new responsibility is more consistent with the mission of this agency than is its current responsibility. (The mission and goals of the HSA are shown at the end of this document on page 7.)

- The HSC members would be absorbed into the membership of the larger Long-Term Care Commission.

The membership of the current Health Services Commission includes:

1. A representative of the Arkansas Health Care Association (representing nursing home owners)
2. A representative of the Residential Care Association
3. A representative of the Arkansas Hospital Association[1]
4. A representative of the Hospice Association
5. A representative of the Home Health Association
6. A person knowledgeable about business health insurance
7. A practicing physician[2]
8. A representative of the Department of Human Services
9. A representative of AARP[3]

Composition of the Commission:

1) A Commission Director, who shall be appointed by, and serve at the pleasure of, the Governor.
2) Legislators. (A member of the Senate, appointed by the President of the Senate and a member of the House of Representatives, appointed by the Speaker of the House.)[4]
3) Provider organizations:
   - Arkansas Association of Area Agencies on Aging
   - DDS Board
   - Developmental Disabilities Providers Association
   - The ARC of Arkansas
4) Consumers (senior citizens and people with disabilities):
   - A member of People First
   - A member of AARP
   - A member with a mental illness
5) Advocates representing the following groups:
   - AARP
   - ADAPT
   - Arkansas Disability Coalition
   - Association of HDC Parents
   - Autism Society
   - Disability Rights Center
   - Mental Health Council of Arkansas
   - NAMI-Arkansas
   - Partners for Inclusive Communities
   - The DD Council
   - The Independent Living Council

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[1] The individual currently serving is also a nursing home owner.

[2] This position is currently vacant. However, the physician previously occupying this position was also a nursing home owner.

[3] This individual is the only consumer on the board.

[4] We are awaiting input from Butch Reeves on how to word this section to involve legislators.

NOTE WELL: The number of individuals in 4) and 5) should be greater than the number of all representatives of provider organizations to ensure an equal voice for consumers.

6) The Directors of DHS-MS, DHS-AAS, DHS-DD, DHS-MH
7) A representative from Arkansas Rehabilitation Services
8) A representative from the Arkansas Workforce Investment Board
9) A representative from the Department of Education
10) A representative from the Department of Health
11) A representative from the Department of Labor
12) A representative from the Department of Workforce Education
13) A representative from the Disability Rights Center
14) A representative from the Employment Security Division
15) A representative from the Nursing Commission
16) A representative from the Social Security Administration (Disability Determination)

Roles of the Commission:

1. Evaluate the state's long-term care service delivery system and make recommendations to increase the availability and the use of non-institutional settings to provide care to the elderly and people with disabilities.
2. Analyze all legislation, rules, regulations, and methodologies for their impact on the entire continuum of care. All proposed bills, rules, regulations or methodologies dealing with any aspect of health care would be submitted to the Long-Term Care Commission for an analysis that would accompany the document when it goes to the legislature.
3. Ensure close communication and coordination among state agencies involved in developing and administering a more efficient and coordinated long-term care service delivery system in this state.
4. Develop strategies and write legislation to implement immediate reforms designed to:
    - Facilitate having the money follow the person, possibly through the use of health care vouchers.
    - Stimulate competition between health care providers based on quality of care.
5. Continually monitor budget issues and look for additional sources of funds, including federal and private grants.
6. Focus on providing services and supports for all populations of people with disabilities who are currently underserved due to:
    - Geographic location
    - Type of disability, or
    - Exclusion based on age or lack of funding (waivers or other funding streams)
    - Dual diagnosis (mental illness and developmental disability)
7. Develop a statewide plan to monitor health care consumption and worker availability.
8. Address all issues related to recruitment, education and retention of health care workers and recommend changes to address long-term direct care workforce needs over time.
9. Develop strategies to monitor the quality of home- and community-based services. Review current programs providing long-term care services to

determine whether the programs are cost effective, of high quality, and operating efficiently.
10. Review the Nurse Practice Act to assist the state in becoming more Olmstead compliant.
11. Collaborate with DHS on an ongoing public awareness program to educate consumers about home- and community-based services and supports and institutional alternatives.
12. Explore all avenues to distribute information to consumers about their long-term care options, using city, county, and local Workforce Center offices.

Mission and Purpose of the Health Services Permit Agency:

The Health Services Permit Agency, with direction from a nine member Health Services Permit Commission, is responsible for issuing Permits of Approval (POAs) for Nursing Homes, Residential Care Facilities, Assisted Living Facilities, Home Health and Hospice Agencies, Psychiatric Residential Care Facilities and Intermediate Care Facilities for the Mentally Retarded.

The Commission/Agency mission is to ensure appropriate distribution of health care providers through the regulation of new services, protection of quality care and negotiation of competing interests so that community needs are appropriately met without unnecessary duplication and expense.

Goals and Objectives:

1. Evaluate the availability and adequacy of health facilities and health services as they relate to long-term care facilities and home health care service agencies in Arkansas.
2. Designate those areas of the state and specify categories of health services, which are underserved or over served, and exempt certain underserved areas or categories of service from the permit of approval process.
3. Develop policies and adopt criteria for the review of applications and issuing of permits of approval.

PUBLIC AWARENESS RECOMMENDATIONS

91. 20 For 0 Against Develop DHS web *site listing consumer* services linked from its main site. It should be written for the lay person, be brief, concise, and *accessible to all individuals*. It should explain the implications of Olmstead in simple terms. This *site* should be linked from every DHS division web site and from the state's home page.

The web site should include all supports and services available to individuals with disabilities and their families. At a minimum, the site should include for each service: the name of service; type of individuals served; geographic area covered; eligibility criteria; and capacity. The site should include a self-assessment option for users. A comprehensive search engine for the site should be developed and maintained. Finally, the site should provide hyper links to national and regional service and information

providers. These objectives should be completed by July, 2003. However, some objectives, such as updating the database and maintenance will be ongoing.

92. 21 For 0 Against DHS needs to make the current DHS web site more user friendly. There should be more uniformity and consistency among the division web sites. A user-friendly version of the Arkansas Olmstead Plan should be accessible from every DHS web site as well as the state's home page, and the unexpurgated plan should be available as well.

93. 21 For 0 Against Other informational formats, corresponding with the improved web site (see numbers 1 and 2) should be available. These include a *service directory* and a toll-free phone referral system.

A. The *service directory* should follow, as closely as possible, the format of the web site. An informational tree *format* is recommended, though there should be no wrong "branch." In other words, a person can easily find what services he or she would be eligible for by referring to such a *directory*, without having to read the whole *directory*.
B. Similarly, the contact person at each DHS division should be able *use* the *directory* or web site as a template to refer the consumer to the appropriate area. This should reduce "run around" when consumers call by phone. (See Supports and Services recommendation on Single Point of Information.)
C. A brochure or informational card should be made available to the public that is easy to read and concise. It should list the various services and corresponding telephone numbers.

94. 17 For 2 Against DHS should develop a media relations package in a collaborative effort with the Public Awareness Committees of the Governor's Task Force on Supported Housing (GTFSH) and the Governor's Integrated Services Task Force (GIST).

95. 12 For 8 Against DHS should maintain a Public Awareness consumer advisory committee, comprised in majority of persons with disabilities and parents of children with disabilities.

96. 15 For 4 Against DHS should request that Legislative Research disseminate periodically informational bulletins to the legislators and assist them with constituent concerns.

SUPPORT AND SERVICES RECOMMENDATIONS

NURSING HOME

97. 17 For 3 Against Funding will follow the individual from setting to setting.

98. 18 For 2 Against Dispense with Permit of Approval process for nursing homes and assisted living facilities (let free enterprise determine need). TIMELINE: JULY 2003

99. 18 For 3 Against Require functional assessments of all public and private pay residents to nursing home placement.

COMPREHENSIVE CASE MANAGEMENT SYSTEM

100. 15 For 7 Against Develop a comprehensive case management system that is comprised of case managers who have received specialized training and certification that equip the case managers to prove case management across all services delivery systems. The case managers, available as an option, may serve as a single point of contact/entry into the multiple service systems. Case managers should present as many choices to clients as possible and should act in response to consumer* direction. (*consumer/family) TIMELINE: July 2004

101. 16 For 5 Against Design a standardized certification and training system (competency based, with levels) for comprehensive case managers. Curriculum topics will include at a minimum: natural supports, transportation, housing, access and eligibility and quality assurance.
TIMELINE: RFP ISSUED JANUARY 2003
CURRICULUM COMPLETED DECEMBER 2003

102. 14 For 5 Against Develop a media campaign to educate individuals about this new service. TIMELINE: JULY 2004

MEDICATION

103. 20 For 0 Against Include in the standardized resource directory (to be developed), a link to all pharmaceutical assistance programs.

104. 21 For 0 Against Review, and if necessary, legislatively, adopt a Nurse Delegation Act to allow more flexibility within the community-based care system. Review success in other states as a model for Arkansas (Ref. Oregon and Florida).
TIMELINE: REVIEW PROCESS BY OCTOBER 2002
IMPLEMENTATION BY JULY, 2003

105. 16 For 4 Against Medication access/reimbursement is tied to the individual, not the service setting. (Currently individuals can gain access to a greater number of medications in an institutional setting, then they can in the community.)

106. 13 For 6 Against All medications presently discarded by nursing homes should be used and made available to individuals regardless of their service setting.

REGIONAL COOPERATIVE

107. 13 For 8 Against Requests for Proposals (RFP's) should be issued (especially in rural areas) to begin the development of Regional Cooperatives to extend community-based services, such as: transportation, respite/crisis services, medication access, administrative resources, purchasing power and other needs. The purpose is to promote infrastructure development, where services are minimal or non-existent.

108. 19 For 1 Against Ultimately, the best outcome will be the development of a seamless delivery system of home, community and institutions. Staffs should become part of a common team focused on the client, rather than the system.

NATURAL SUPPORTS

109. 17 For 2 Against Increase community education on the topic of natural supports. Natural supports include non-paid individuals who form an informal network to assist individuals. The network may include; church members, neighbors, colleagues, friends, acquaintances, classmates, etc.

TRANSPORTATION

110. 21 For 0 Against The GIST should work with appropriate state agencies to develop and overall state plan for transportation that can reasonably accommodate people with disabilities, building upon existing transportation systems.

111. 20 For 1 Against Arkansas should examine and seek to address the need for transportation other than non-emergency medical care.

112. 21 For 0 Against Transportation programs should address the need for an aide or assistant for people who require extra assistance.

113. 20 For 0 Against Reimbursement methodologies should recognize the costs for training and testing drivers, aides, or both, to meet the needs of specialized groups who may require enhanced communications or physical transfer skills.

COLLABORATION

114. 19 For 0 Against Representatives from various groups that have been formed to come up with plans for the state for people with disabilities should meet to monitor the status of their plans. Some of those groups include: Supportive Housing Task Force, any active GIST Subcommittees and the Mental Health System Task Force.

QUALITY ASSURANCE

Continuing Quality Improvement is a critical piece of any service delivery system. We have defined Continuing Quality Improvement for services for people with disabilities as,

"A responsive feedback system that maximizes self direction and minimizes risk."

Any process considered should include four basic components:
1. A system of measurement and quality improvement activities for all populations (outcomes),
2. The availability of advocates, ombudsmen, or other individual representatives,
3. Established principles, expectations, and standards for all types of services,
4. An independent system of monitoring and evaluating services.

115. 14 For 4 Against It is our sole recommendation that the Governor form an ongoing commission to address Continuing Quality Improvement issues for all disabilities.

Appendix C

Waiver Services

While Arkansas can and will make improvements to its long term care system, the State has a strong record in giving consumers a choice of how and where they receive long term care outside institutions. Below is a brief description of DHS' four Home and Community Based Services (HCBS) that are funded through waivers from Medicaid.

Division of Aging and Adult Services

- **ElderChoices** is Arkansas' home and community based care waiver for the elderly, On any given day about 6,000 older Arkansans receive care in their homes through this nursing home diversion program.

- **Alternatives** is a second nursing home diversion program for younger individuals with physical disabilities.

- **IndependentChoices** is a form of consumer directed Personal Care. Arkansas was the first state in the nation to implement this Cash and counseling program.

Division of Developmental Disabilities Services

- **Alternative Community Services** is one of the fastest growing waiver programs for person with developmental disabilities in the nation and serves persons of any age.

Additional information on the Waivers:

Division of Aging and Adult Services Waiver Programs

ElderChoices is Arkansas' Medicaid home and community-based waiver designed for its elderly population. ElderChoices, implemented July 1, 1991, is designed for persons who due to physical, cognitive or medical reasons, require a level of assistance that would have to be provided in a nursing facility, if it were not for the services offered through this program. The program is designed to assist elderly persons reside in their own homes, or live with relatives or caregivers for as long as possible, if that is their choice.
ElderChoices has provided services to more than 13,000 elderly Arkansans since 1991.

The services offered through this program include:

 Homemaker - includes basic upkeep and management of the home and household assistance, such as laundry, essential shopping, errands, household tasks and meal preparation.

 Chore - provides heavy cleaning and/or yard and sidewalk maintenance in extreme circumstances, when lack of these services would make the home uninhabitable.

 Home Delivered Meals - Nutritious home-delivered meals provided to individuals who are homebound and unable to prepare their own meals.

 Personal Emergency Response System (PERS) - provides an in-home 24-hour electronic alarm system that enables an elderly homebound person to summon help in the event of an emergency.

 Adult Day Care - provides for a group program designed to provide care and supervision in a licensed adult day care facility.

 Adult Day Health Care - provides a continuing, organized program of rehabilitative, therapeutic and supportive health and social services and activities in addition to basic day care.

 Adult Foster Care - provides a family living environment for one or two clients who are functionally impaired and are considered to be at imminent risk of death or serious bodily harm and are not capable of living alone.

 Respite - provides temporary relief to persons providing long term care for clients in their homes. It may be provided in and/or outside of the client's home to meet an emergency need or as periodic scheduled relief from continuous care giving.

In addition to ElderChoices services, waiver recipients may receive other Medicaid covered services such as physician visits, some prescription drugs, personal care and others.

Alternatives

Alternatives is a Medicaid Waiver program that provides home and community-based services to a limited number of adults with physical disabilities.

Alternatives offers two consumer-directed services:

- *Attendant Care*: Assistance to accomplish tasks of daily living, based on need and approved by the physician. Based on need, the client may receive up to 8 hours a day, 7 days a week of attendant care. The client shall recruit, hire, supervise and approve payment of the attendant. Although the attendant may be a family member, it may NOT be a spouse or other legally responsible person.

- *Environmental Adaptations*: Modifications to the environment that increase independence or accessibility.

Who can apply?
Anyone who:

- Has a physical disability and income of no more than 300% of SSI

- Is between 21 and 64 years old

- Meets eligibility for Intermediate Level Nursing Home Placement
  Note: To be eligible for Intermediate level nursing home placement, the individual must require extensive assistance with 1 ADL or limited assistance with 2 ADLs (ADLs considered are transferring/locomotion, eating or toileting), or have a diagnosis of dementia, or have a medical condition that requires daily

monitoring by a medical professional. Individuals that required skilled care cannot be served.

- Has in-home service expenditures of no more than the cost of nursing home placement.

Independent Choices

The state of Arkansas offers a cash payment program called Independent-Choices, which substitutes a cash allowance for Medicaid services from provider agencies. People with disabilities are randomly assigned into two groups. The control group receives Medicaid personal care through a provider agency and the treatment group receives a monthly cash allowance and services to help them effectively use the allowance. Historical data indicates treatment group participants have less nursing home utilization than control group participants.

People age 18 and older eligible for Medicaid personal care can enroll in IndependentChoices at any time. People with cognitive impairments are also eligible. A person can choose a representative to administer the cash allowance on his or her behalf.

People in the treatment group have a lot of flexibility in how they use the cash allowance. Unlike people in the control group, these people can hire whomever they wish, including family and friends (other than spouses). Participants can also purchase items related to personal assistance, including assistive technology, appliances, and home modifications. Counseling/fiscal agencies, operating regionally, offer a wide variety of assistance to help people manage their cash allowance. To ensure the services are enough to meet participant needs and to monitor possible fraud or abuse, the counseling/fiscal agency contacts each person once a month and conducts an in-person reassessment every six months.

IndependentChoices required a Medicaid research and demonstration waiver authorized by Section 1115 of the Social Security Act. The waiver permits the state to disregard certain federal Medicaid rules such as providing cash to recipients. The project also negotiated with other federal agencies to ensure the cash allowance would not affect a participant's Social Security Income, food stamps, and other benefits.

Assisted Living (waiver pending)

The Assisted Living Federation of America defines **Assisted Living** as a special combination of housing, supportive services, personalized assistance and healthcare designed to respond to the individual needs of those who need help with activities of daily living. Supportive services are available, 24 hours a day, to meet scheduled and unscheduled needs, in a way that promotes maximum dignity and independence for each resident and involves the resident's family, neighbors and friends.

A Medicaid Assisted Living waiver is not yet in place in Arkansas, but the Robert Wood Johnson Foundation and NCB Development Corporation selected Arkansas as one of nine states to participate in the Coming Home Program. Coming Home seeks to develop affordable assisted living for low to moderate-income individuals.

The Coming Home program seeks to create models of assisted living that will serve low-income seniors including those on Medicaid, ie those with incomes of $545 per month. With that in mind, the goal of Coming Home projects is to reduce the shelter payment to about $350-$400 per month, with services funded through Medicaid.

The Arkansas Department of Human Services (ADH) has issued **Regulations for Assisted Living**. DHS promulgated the regulations in accordance with the Arkansas Administrative Review Process, which included a 30-day public comment period. To provide Assisted Living in Arkansas, one must:

- Obtain a Permit of Approval from the Arkansas Health Service Permit Agency, and

Obtain a License from the AR Department of Human Services Office of Long Term Care.

Developmental Disabilities Services Waiver Program

Alternative Community Services (ACS)

Current approved waiver services

Supportive Living Services are an array of individually tailored services and activities provided for eligible persons to enable them to reside successfully in their own homes, with their families, or in an alternate living residence or setting. These services fall into two general categories:

- **Residential Habilitation Supports** are designed to assist the person in acquiring, retaining or improving his/her skill in a wide variety of areas that directly affect his/her ability to reside as independently as possible in the community. These services provide the supervision necessary to live in the community. These supports, habilitative in nature, may address areas of need such as self-direction, money management, daily living skills, socialization, community integration, mobility, communication or behavior shaping, and management.
- **Residential Habilitation Reinforcement Supports** are supports that may be provided to an eligible person to reinforce therapeutic services, assist or supervise the person in performance of tasks such as meal preparation, shopping, etc. These services, however, cannot be performed separately from other waiver services. Companion and activities therapy services are included in this area of service and recognize the use of animals as a treatment modality to reinforce therapeutic goals.

Community Experiences Services are a flexible array of supports designed to allow persons to gain experience and abilities that will prevent institutionalization. Through this broad base of learning opportunities, eligible persons will identify, pursue and gain skills and abilities that reflect their interest. This model helps to improve community acceptance, employment opportunities and overall general well being

Respite Care provided under the ACS waiver fall into two distinct categories:

- **Respite Child Care Support Services** are services that promote access to and participation in child care through a combination of basic child care and support services for eligible children ages birth to 18 years. These services are to be provided only in the absence of the primary caregiver during those hours when the caregiver is at work, in job training or at school. Services may be provided in a variety of settings to include licensed day care, extended day programs, etc.

Participation fees are responsibility of parent. Waiver pays only for the support staff required due to developmental disability.

- Respite services may be provided for any eligible individual regardless of age on a short-term basis because of the need for relief of the unpaid primary caregiver.

Environmental Modifications are those adaptations to the eligible person's place of residence (structure) which are necessary to ensure the health, welfare and safety of the person or which enable him/her to function with greater independence within the home environment. Modifications may include widening of doorways, installation of ramps or grab bars, etc.

Adaptive equipment service provides for the purchase, leasing and, as necessary, repair of adaptive, therapeutic and augmentative equipment required to enable persons to increase, maintain or improve their functional capacity to perform daily life tasks that would not be possible otherwise.

Specialized medical needs allow for additional supply items to be covered as a waiver service when they are essential for home and community care. Examples of such items include disposable incontinence undergarments, nutritional supplements, etc. When such items are covered in the Medicaid State plan, this will be an extension of such services and can be accessed only after reaching state plan benefit limit with a prescription.

Supplemental Support services are designed to meet the needs of the person to improve or enable continuance of community living, to allow the opportunity to participate in integrated leisure, recreational, and social activities and make a positive difference in the life of the person. Supplemental supports may include emergency medical cost such as prescriptions drug co-pay, transitional expenses for initial integration into the community when transitioning from an ICF/MR or nursing home to the waiver etc.

Supported Employment services are designed for persons for whom competitive employment at or above the minimum wage is unlikely, or who, because of their disabilities, need intensive, ongoing support to perform in a competitive work setting. The employer is responsible for making reasonable accommodations in accordance with the American's with Disabilities Act. Reimbursement cannot be claimed if the person is not able to perform the essential functions of the job.

Consultation Services are services that assist persons, parents/guardians/responsible individuals, community living services providers and alternative living setting providers in carrying out the person's service plan. Consultation may include behavioral, nursing assessment etc.

Crisis Services-center based is 24 hour emergency care services for eligible persons with priority given to persons with a dual diagnosis. Admission is limited to persons in a crisis situation where current placement is no longer viable and immediate alternate placement cannot be identified.

Waiver Coordination services are provided to assure the delivery of all direct care services. This includes the coordination of all direct services care workers provided through the direct service provider, coordination of schedules for both waiver and

generic service categories and other activities necessary for appropriate service delivery in accordance with the plan of care.

Waiver Case Management is a system of ongoing monitoring of the provision of services included in the plan of care. Also included in this service are activities such as arranging for the provision of services and additional supports, facilitating intervention during crisis intervention, case planning, needs assessment and referral for resources, etc.

After amendments are promulgated, there will be three distinct service models available under the ACS Home and Community Based Waiver. They are:

- **Traditional Service Model**: Services are delivered through a DDS licensed and Medicaid enrolled service provider network with all service coordinated through a Case Management provider of the eligible person's choice.
- **Self-Determined Model**: Eligible persons needing Supported Living Services have the option of hiring and otherwise managing their direct caregivers.
- **Supported Living Arrangement Model**: Care is provided in DDS supported living arrangements in supported living apartments, follow along in-home and in group homes up to 15 beds